



## ***Texas Department of Insurance***

### ***Division of Workers' Compensation***

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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## ***MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION***

### ***GENERAL INFORMATION***

#### **Requestor Name and Address**

ENCINO MEDICAL CENTER  
c/o LAW OFFICES OF P. MATTHEW O'NEIL  
6514 MCNEIL DRIVE BLDG 2 SUITE 201  
AUSTIN, TX 78729

#### **DWC Claim #:**

**Injured Employee:**

**Date of Injury:**

**Employer Name:**

**Insurance Carrier #:**

#### **Respondent Name**

TEXAS MUTUAL INSURANCE CO

#### **Carrier's Austin Representative Box**

54

#### **MFDR Tracking Number**

M4-08-7184-02

#### **MFDR Date Received**

July 17, 2008

### ***REQUESTOR'S POSITION SUMMARY***

**Requestor's Position Summary:** "As set forth in the attached billing and records, the claimant in this case was admitted and received an inpatient procedures and treatment relating to an on the job injury. Specifically, the claimant was injured on the job on 6/1/06 fracturing his femur. The admission made the basis of this dispute relates to removal of hardware, a femur rod. All billing and records relating to the services are enclosed and attached hereto ... After discharge, the Hospital submitted the claim. Since the total charges for the medical services exceeded the stop loss threshold under Texas Fee Guidelines in effect at the time, the carrier was required to pay 75% of the charges ... As described above, Texas law and workers compensation rules require claims exceeding \$40,000.00 to be paid at a 75% of charges."

**Amount in Dispute:** \$39,915.02

### ***RESPONDENT'S POSITION SUMMARY***

**Respondent's Position Summary Dated September 2, 2008:** "The following is the carrier's statement with respect to this dispute This dispute involves whether Texas Mutual's payment is subject to stop loss for date of service 7/17/07 to 7/20/2007. The requestor billed \$57,707.96; Texas Mutual paid \$3,365.95. The requestor believes it is entitled to an additional \$39,915.02 ... In this dispute, the requestor has not provided any additional information to justify the required services were unusually costly or unusually extensive ... In conclusion, the admission did not have services that were unusually extensive or unusually costly and total audited charges do not exceed the minimum threshold of \$40,000. Payment under the stop-loss exception has not been justified by the hospital in this case, and Texas Mutual's payment under the per diem plus carve-outs method is appropriate."

**Response Submitted by:** Texas Mutual

## SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
July 17, 2007	Inpatient Hospital Services	\$39,915.02	\$0.00

## FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

### Background

1. 28 Texas Administrative Code §133.305 and §133.307, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401, 22 *Texas Register* 6264, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.

The services in dispute were reduced/denied by the respondent with the following reason codes:

#### Explanation of Benefits dated October 08, 2007

- CAC-W1 – Workers compensation state fee schedule adjustment
- CAC-62 – Payment denied/reduced for absence of, or exceeded, pre-certification/authorization
- CAC-97 – Payment is included in the allowance for another service/procedure
- 480 – Reimbursement based on the acute care inpatient hospital fee guideline per diem rate allowances
- 711 – Length of stay exceeds number of days previously preauthorized. Documentation does not support medical necessity for additional days
- 730 – Denied as included in per diem rate

#### Explanation of Benefits dated January 03, 2008

- CAC-W1 – Workers compensation state fee schedule adjustment
- CAC-W4 – No additional reimbursement allowed after review of appeal/reconsideration
- CAC-143 – Portion of payment deferred
- CAC-97 – Payment is included in the allowance for another service/procedure
- 420 – Supplemental payment
- 480 – Reimbursement based on the acute care inpatient hospital fee guidelines
- 730 – Denied as included in per diem rate
- 891 – The insurance company is reducing or denying payment after reconsideration

Dispute M4-08-7184 was originally decided on October 14, 2008 and subsequently appealed to a contested case hearing at the State Office of Administrative Hearings (SOAH) under case number 454-09-1314.M4. This dispute was then remanded to the Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) pursuant to a February 16, 2009 SOAH order of remand. As a result of the remand order, the dispute was re-docketed at medical fee dispute resolution and is hereby reviewed.

### Issues

1. Did the audited charges exceed \$40,000.00?
2. Did the admission in dispute involve unusually extensive services?
3. Did the admission in dispute involve unusually costly services?
4. Is the requestor entitled to additional reimbursement?

### Findings

This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of division rule at 28 Texas Administrative Code §134.401, titled *Acute Care Inpatient Hospital Fee Guideline*, effective August 1, 1997, 22 *Texas Register* 6264. The Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 *South Western Reporter Third* 538, 550 (Texas Appeals – Austin 2008, petition denied) addressed a challenge to the

interpretation of 28 Texas Administrative Code §134.401. The Court concluded that “to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed \$40,000 and that an admission involved unusually costly and unusually extensive services.” Both the requestor and respondent in this case were notified via form letter that the mandate for the decision cited above was issued on January 19, 2011. Each party was given the opportunity to supplement their original MDR submission, position or response as applicable. The documentation filed to the division by the requestor and respondent as noted above is considered. Consistent with the Third Court of Appeals’ November 13, 2008 opinion, and 28 Texas Administrative Code §134.401(c)(6), the division will address whether the requestor demonstrated that: audited charges **in this case** exceed \$40,000; the admission and disputed services **in this case** are unusually extensive; and that the admission and disputed services **in this case** are unusually costly.

1. 28 Texas Administrative Code §134.401(c)(6)(A)(i) states “...to be eligible for stop-loss payment the total audited charges for a hospital admission must exceed \$40,000, the minimum stop-loss threshold.” Furthermore, (A) (v) of that same section states “...Audited charges are those charges which remain after a bill review by the insurance carrier has been performed...” Review of the explanation of benefits issued by the carrier finds that the carrier did not deduct any charges in accordance with §134.401(c)(6)(A)(v); therefore the audited charges equal \$57,707.96. The division concludes that the total audited charges exceed \$40,000.
2. The requestor in its position statement asserts that “After discharge, the Hospital submitted the claim. Since the total charges for the medical services exceeded the stop loss threshold under Texas Fee Guidelines in effect at the time, the carrier was required to pay 75% of the charges ... As described above, Texas law and workers compensation rules require claims exceeding \$40,000.00 to be paid at a 75% of charges.” The requestor presumes that it is entitled to the stop loss method of payment because the audited charges exceed \$40,000. As noted above, the Third Court of Appeals in its November 13, 2008 rendered judgment to the contrary. The Court concluded that “to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed \$40,000 and that an admission involved...unusually extensive services.” The requestor failed to discuss or demonstrate that the particulars of the admission in dispute constitute unusually extensive services; therefore, the division finds that the requestor did not meet 28 TAC §134.401(c)(6).
3. In regards to whether the services were unusually costly, the requestor presumes that because the bill exceeds \$40,000, the stop loss method of payment should apply. The third Court of Appeals’ November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must **demonstrate** that an admission involved unusually costly services thereby affirming 28 Texas Administrative Code §134.401(c)(6) which states that “Stop-loss is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker.” The requestor failed to discuss the particulars of the admission in dispute that constitute unusually costly services; therefore, the division finds that the requestor failed to meet 28 TAC §134.401(c)(6).
4. For the reasons stated above the services in dispute are not eligible for the stop-loss method of reimbursement. Consequently, reimbursement shall be calculated pursuant to 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount* and §134.401(c)(4) titled *Additional Reimbursements*. The division notes that additional reimbursements under §134.401(c)(4) apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section.
  - The length of stay was three days; however, documentation supports that the Carrier pre-authorized a length of stay of three days in accordance with 28 Texas Administrative Code Rule §134.600. Consequently, the per diem rate allowed is \$3,354.00 for the three authorized days.

The division concludes that the total allowable for this admission is \$3,354.00. The respondent issued payment in the amount of \$3,365.95. Based upon the documentation submitted, no additional reimbursement can be recommended.

## **Conclusion**

The submitted documentation does not support the reimbursement amount sought by the requestor. The requestor in this case demonstrated that the audited charges exceed \$40,000, but failed to demonstrate that the disputed inpatient hospital admission involved unusually extensive services, and failed to demonstrate that the services in dispute were unusually costly. Consequently, 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount*, and §134.401(c)(4) titled *Additional Reimbursements* are applied and result in no additional reimbursement.

## ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

### Authorized Signature

_____	_____	12/20/12
Signature	Medical Fee Dispute Resolution Officer	Date

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**